106TH CONGRESS
2D SESSION

S. 2237

To amend the Internal Revenue Code of 1986 to provide for the deductibility of premiums for any medigap insurance policy or Medicare+Choice plan which contains an outpatient prescription drug benefit, and to amend title XVIII of the Social Security Act to provide authority to expand existing medigap insurance policies.

IN THE SENATE OF THE UNITED STATES

MARCH 9, 2000

Mr. CRAIG introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend the Internal Revenue Code of 1986 to provide for the deductibility of premiums for any medigap insurance policy or Medicare+Choice plan which contains an outpatient prescription drug benefit, and to amend title XVIII of the Social Security Act to provide authority to expand existing medigap insurance policies.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Seniors' Security Act of 2000''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. DEDUCTION FOR PREMIUMS FOR MEDIGAP INSURANCE POLICIES AND MEDICARE+CHOICE PLANS CONTAINING OUTPATIENT PRESCRIPTION DRUG BENEFITS AND FOR LONG-TERM CARE INSURANCE.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions) is amended by redesignating section 222 as section 223 and by inserting after section 221 the following:

"SEC. 222. PREMIUMS FOR MEDIGAP INSURANCE POLICIES AND MEDICARE+CHOICE PLANS CONTAINING OUTPATIENT PRESCRIPTION DRUG BENEFITS AND FOR LONG-TERM CARE INSURANCE.

''(a) DEDUCTION.—

''(1) IN GENERAL.—There shall be allowed as a deduction an amount equal to 100 percent of the amount paid during the taxable year for—

''(A) any medicare supplemental policy (as defined in section 1882(g)(1) of the Social Security Act) which contains an outpatient prescription drug benefit with an annual actuarial value that is equal to or greater than $500,

''(B) any Medicare+Choice plan (as defined in section 1859(b)(1) of such Act) which contains an outpatient prescription drug benefit with an annual actuarial value that is equal to or greater than $500, and

''(C) any coverage limited to qualified long-term care services (as defined in section 7702B(c)) or any qualified long-term care insurance contract (as defined in section 7702B(b)).

''(2) INFLATION ADJUSTMENT.—

''(A) IN GENERAL.—In the case of any calendar year beginning after 2000, each of the dollar amounts in subparagraphs (A) and (B) of paragraph (1) shall be increased by an amount equal to—

''(i) such dollar amount, multiplied by

''(ii) an adjustment for changes in per capita expenditures under title XVIII of the Social Security Act for prescription

drugs as determined under the most recent Health Care Financing Administration National Health Expenditure projection.

''(B) ROUNDING.—If any dollar amount after being increased under subparagraph (A) is not a multiple of $10, such dollar amount shall be rounded to the nearest multiple of $10.

''(b) LIMITATIONS.—

''(1) DEDUCTION NOT AVAILABLE TO INDIVIDUALS ELIGIBLE FOR EMPLOYER-SUBSIDIZED COVERAGE.—

''(A) IN GENERAL.—In any taxable year—

''(i) subsection (a) shall not apply with respect to any policy or coverage described in paragraph (1)(A) or (1)(B) of such subsection if in such taxable year the taxpayer is eligible to participate in any employer-subsidized plan for individuals age 65 or older which contains an outpatient prescription drug benefit described in such subsection, and

''(ii) subsection (a) shall not apply with respect to any policy or coverage described in paragraph (1)(C) of such subsection if in such taxable year the taxpayer

is eligible to participate in any employer-subsidized plan which includes coverage for qualified long-term care services (as so defined) or any qualified long-term care insurance contract (as so defined).

''(B) EMPLOYER-SUBSIDIZED PLAN.—For purposes of subparagraph (A)—

''(i) IN GENERAL.—The term 'employer-subsidized plan' means any plan described in subparagraph (A)—

''(I) which is maintained by any employer (or former employer) of the taxpayer or of the spouse of the taxpayer, and

''(II) 50 percent or more of the cost of the premium of which (determined under section 4980B) is paid or incurred by the employer.

''(ii) EMPLOYER CONTRIBUTIONS TO CAFETERIA PLANS, FLEXIBLE SPENDING ARRANGEMENTS, AND MEDICAL SAVINGS ACCOUNTS.—Employer contributions to a cafeteria plan, a flexible spending or similar arrangement, or a medical savings account which are excluded from gross in-

come under section 106 shall be treated for purposes of this subparagraph as paid by the employer.

''(C) AGGREGATION OF PLANS OF EMPLOYER.—A health plan which is not otherwise described in subparagraph (A) shall be treated as described in such subparagraph if such plan would be so described if all health plans of persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 were treated as one health plan.

''(D) SEPARATE APPLICATION TO HEALTH INSURANCE AND LONG-TERM CARE INSURANCE.—Subparagraphs (A) and (C) shall be applied separately with respect to—

''(i) plans which include coverage limited to qualified long-term care services or are qualified long-term care insurance contracts, and

''(ii) plans which do not include such coverage and are not such contracts.

''(E) DEDUCTION AVAILABLE WITH RESPECT TO POLICIES AND PLANS CONTAINING OUTPATIENT PRESCRIPTION DRUG COVERAGE IF DISCLOSURE REQUIREMENTS ARE MET.—Sub-

section (a) shall apply in any taxable year with respect to any policy or plan described in paragraph (1)(A) or (1)(B) of such subsection only if the issuer of such policy or the administrator of such plan discloses to the taxpayer that such policy or plan is intended to be a policy or plan so described.

''(2) DEDUCTION NOT AVAILABLE FOR PAYMENT OF PART B PREMIUMS.—Any amount paid as a premium under part B of title XVIII of the Social Security Act shall not be taken into account under subsection (a).

''(3) LIMITATION ON LONG-TERM CARE PREMIUMS.—In the case of a qualified long-term care insurance contract (as so defined), only eligible long-term care premiums (as defined in section 213(d)(10)) shall be taken into account under subsection (a)(2).

''(c) SPECIAL RULES.—For purposes of this section—

''(1) COORDINATION WITH MEDICAL DEDUCTION, ETC.—Any amount paid by a taxpayer for insurance to which subsection (a) applies shall not be taken into account in computing the amount allow-

able to the taxpayer as a deduction under section 213(a).

''(2) DEDUCTION NOT ALLOWED FOR SELF-EMPLOYMENT TAX PURPOSES.—The deduction allowable by reason of this section shall not be taken into account in determining an individual's net earnings from self-employment (within the meaning of section 1402(a)) for purposes of chapter 2.''

(b) CONFORMING AMENDMENTS.—

(1) Subsection (a) of section 62 of the Internal Revenue Code of 1986 is amended by inserting after paragraph (17) the following:

''(18) MEDICARE AND LONG-TERM CARE INSURANCE COSTS OF CERTAIN INDIVIDUALS.—The deduction allowed by section 222.''

(2) The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following:

''Sec. 222. Premiums for medigap insurance policies and Medicare+Choice plans containing outpatient prescription drug benefits and for long-term care insurance.
''Sec. 223. Cross reference.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1999.

SEC. 3. DETERMINATION OF ANNUAL ACTUARIAL VALUE OF DRUG BENEFITS COVERED UNDER A MEDICARE+CHOICE PLAN AND A MEDIGAP POLICY.

(a) IN GENERAL.—For purposes of subparagraphs (A) and (B) of section 222(a)(1) of the Internal Revenue Code of 1986 (as added by section 2), the Secretary of Health and Human Services shall establish procedures for a Medicare+Choice organization offering a Medicare+Choice plan under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.) or an issuer of a medicare supplemental policy (as defined in section 1882(g)(1) of such Act (42 U.S.C. 1395ss(g)(1))) to demonstrate that the annual actuarial value of the outpatient prescription drug benefit offered under such plan or policy is equal to or greater than the amount described in section 222(a)(1) of the Internal Revenue Code of 1986 that is applicable for the year involved.

(b) REQUIREMENTS.—The procedures established pursuant to subsection (a)—

(1) shall be based on—

(A) a standardized set of utilization and price factors; and

(B) a standardized population that is representative of all medicare enrollees and calculated based on projected utilization if all en-

rollees have outpatient prescription drug coverage;

(2) shall apply the same principles and factors in comparing the value of the coverage of different outpatient prescription drug benefit packages; and

(3) shall not take into account the method of delivery or means of cost control or utilization used by the organization offering the plan or the issuer of the policy.

(c) CONSULTATION.—In establishing the procedures described in subsection (a), the Secretary of Health and Human Services shall consult with an independent actuary who is a member of the American Academy of Actuaries.

(d) UPDATE.—The Secretary shall periodically update the procedures established under subsection (a).

(e) DEMONSTRATION OF ACTUARIAL VALUE.—The actuarial value of the outpatient prescription drug benefit shall be set forth by the Medicare+Choice organization offering the Medicare+Choice plan or the issuer of the medicare supplemental policy in an actuarial report that has been prepared—

(1) by an individual who is a member of the American Academy of Actuaries;

(2) using generally accepted actuarial principles; and

(3) in conformance with the requirements of subsection (b).

SEC. 4. INCLUSION OF QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS IN CAFETERIA PLANS AND FLEXIBLE SPENDING ARRANGEMENTS.

(a) CAFETERIA PLANS.—Section 125(f) of the Internal Revenue Code of 1986 (defining qualified benefits) is amended by inserting before the period at the end ''; except that such term shall include the payment of premiums for any qualified long-term care insurance contract (as defined in section 7702B) to the extent the amount of such payment does not exceed the eligible long-term care premiums (as defined in section 213(d)(10)) for such contract''.

(b) FLEXIBLE SPENDING ARRANGEMENTS.—Section 106 of the Internal Revenue Code of 1986 (relating to contributions by employer to accident and health plans) is amended by striking subsection (c).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1999.

SEC. 5. AUTHORITY TO PROVIDE FOR ADDITIONAL MEDIGAP INSURANCE POLICIES.

(a) IN GENERAL.—

(1) EXPANSION OF NUMBER OF BENEFIT PACKAGES.—Section 1882(p) of the Social Security Act (42 U.S.C. 1395ss(p)) is amended—

(A) in paragraph (2)(B), by striking ", and" and inserting "other than the medicare supplemental policies described in subsection (v); and"; and

(B) in paragraph (2)(C), by striking the period and inserting "and the policies described in subsection (v).".

(2) AUTHORITY TO PROVIDE FOR ADDITIONAL POLICIES.—Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended by adding at the end the following:

"(v) AUTHORITY TO PROVIDE FOR ADDITIONAL POLICIES.—

"(1) IN GENERAL.—The standards under subsection (p) may be modified (in the manner described in paragraph (1)(E) of such subsection (applying paragraph (3)(A) of such subsection as if the reference to 'this subsection' were a reference to 'the Seniors' Security Act of 2000')) to establish additional benefit packages consistent with the succeeding provisions of this subsection.

''(2) REQUIREMENTS FOR NEW PACKAGES THAT INCLUDE PRESCRIPTION DRUG COVERAGE.—In the case of any benefit package added under paragraph (1) that provides coverage for outpatient prescription drugs, such benefit package—

''(A) shall not provide first-dollar coverage of outpatient prescription drugs;

''(B) may provide a stop-loss coverage benefit for outpatient prescription drugs that limits the application of any beneficiary cost-sharing during a year after incurring a certain amount of out-of-pocket covered expenditures;

''(C) shall not include benefits for prescription drugs otherwise available under part A or B; and

''(D) shall be consistent with the requirements of this section and applicable law.

''(3) USE OF FORMULARIES.—In the case of any benefit package added under paragraph (1) that provides coverage for outpatient prescription drugs, the issuer of any policy containing such a benefit package may use formularies.

''(4) SPECIAL OPEN ENROLLMENT.—

''(A) ESTABLISHMENT.—If any benefit package is added under paragraph (1), the Sec-

retary shall establish an applicable period in which any eligible beneficiary may enroll in any medicare supplemental policy containing such benefit package under the terms described in subparagraph (D).

''(B) ELIGIBLE BENEFICIARY DEFINED.—In this paragraph, the term 'eligible beneficiary' means a beneficiary under this title who is enrolled in a medicare supplemental policy as of the first day that any benefit package added under paragraph (1) is available in the State in which such beneficiary resides.

''(C) APPLICABLE PERIOD DEFINED.—In this paragraph, the term 'applicable period' means—

''(i) in the case of an eligible beneficiary who is enrolled in a medicare supplemental policy which has a benefit package classified as 'H', 'I', or 'J' under the standards established under subsection (p)(2), the 180-day period that begins on the day described in subparagraph (B); and

''(ii) in the case of an eligible beneficiary who is enrolled in a medicare sup-

plemental policy which has a benefit package classified as 'A' through 'G' under the standards established under subsection (p)(2), the 63-day period that begins on the day described in subparagraph (B).

''(D) TERMS DESCRIBED.—The terms described under this subparagraph are terms which do not—

''(i) deny or condition the issuance or effectiveness of a medicare supplemental policy described in subparagraph (A) that is offered and is available for issuance to new enrollees by such issuer;

''(ii) discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; or

''(iii) impose an exclusion of benefits based on a preexisting condition under such policy.

''(5) ABILITY FOR ISSUER TO CANCEL CERTAIN POLICIES.—Notwithstanding subsection (q)(2), an issuer of a policy containing a benefit package added under paragraph (1) that provides coverage for out-

patient prescription drugs may terminate such a policy in a market but only if—

"(A) the termination is—

"(i) done in accordance with State law in such market; and

"(ii) applied uniformly to individuals enrolled under such policy;

"(B) the issuer provides notice to each individual enrolled under such policy of such termination at least 90 days prior to the date of the termination of coverage under such policy; and

"(C) the issuer offers to each individual enrolled under such policy, for at least 180 days after providing the notice pursuant to subparagraph (B), the option to purchase all other medicare supplemental policies currently being offered by the issuer under the terms described in paragraph (4)(D).".

(b) SALE OF NON-DUPLICATIVE MEDIGAP INSURANCE POLICIES AUTHORIZED.—Section 1882(d)(3) of the Social Security Act (42 U.S.C. 1395ss(d)(3)) is amended—

(1) in subparagraph (A), by adding at the end the following:

''(ix) Nothing in this subparagraph shall be construed as preventing the sale of more than 1 medicare supplemental policy to an individual, provided that the sale is of a medicare supplemental policy that does not duplicate any health benefits under a medicare supplemental policy owned by the individual.''; and

(2) in subparagraph (B)—

(A) in clause (ii)(I), by inserting '', unless a second policy is designed to compliment the coverage under the first policy'' before the comma at the end; and

(B) in clause (iii)—

(i) in subclause (I), by striking ''(II) and (III)'' and inserting ''(II), (III), and (IV)'';

(ii) by redesignating subclause (III) as subclause (IV); and

(iii) by inserting after subclause (II) the following:

''(III) If the statement required by clause (i) is obtained and indicates that the individual is enrolled in 1 or more medicare supplemental policies, the sale of another policy is not in violation of clause (i) if such other policy does not duplicate health benefits under any policy in which the individual is enrolled.''.

(c) NAIC TO CONSULT WITH MEDPAC IN REVISING MODEL STANDARDS.—

(1) IN GENERAL.—In revising the model regulation under section 1882(v) of the Social Security Act (42 U.S.C. 1395ss(v)) (as added by subsection (a)), the National Association of Insurance Commissioners (in this section referred to as the ''NAIC'') should—

(A) consult with the Medicare Payment Advisory Commission established under section 1805 of such Act (42 U.S.C. 1395b–6) (in this subsection referred to as ''MedPAC''); and

(B) consider the MedPAC report transmitted to NAIC in accordance with paragraph (2)(B)(ii).

(2) MEDPAC ANALYSIS AND REPORT.—

(A) ANALYSIS.—MedPAC shall conduct an analysis of the following issues:

(i) The conditions necessary to create a well-functioning, voluntary medicare supplemental insurance market that provides coverage for outpatient prescription drugs.

(ii) The scope of outpatient prescription drug coverage for medicare bene-

ficiaries, including individuals enrolled in Medicare+Choice plans.

(iii) The implications of a medicare supplemental policy that would require issuers of medicare supplemental policies to provide outpatient prescription drug coverage and a stop-loss benefit instead of providing coverage for other benefits available through existing medicare supplemental policies.

(iv) The portion of out-of-pocket spending of medicare beneficiaries on health care expenses attributable to outpatient prescription drugs.

(v) The availability of private health insurance policies that cover outpatient prescription drugs to beneficiaries that are not entitled to benefits under the medicare program.

(vi) The scope of outpatient prescription drug coverage provided by employers to medicare beneficiaries.

(vii) The impact of outpatient prescription drugs on the overall health of medicare beneficiaries.

(viii) The effect of providing coverage for outpatient prescription drugs on the amount of funds expended by the medicare program.

(ix) Whether modifications of benefit packages of existing medicare supplemental policies that provide coverage for outpatient prescription drugs or the creation of new benefit packages that provide coverage for outpatient prescription drugs would allow payment for these policies to be integrated with a Federal contribution.

(x) Such other issues relating to outpatient prescription drugs that would assist Congress in improving the medicare program.

(B) REPORT TO CONGRESS.—

(i) IN GENERAL.—Not later than June 1, 2000, MedPAC shall submit to Congress a report containing a detailed analysis of the issues described in subparagraph (A) together with recommendations for such legislation and administrative actions as MedPAC considers appropriate.

(ii) TRANSMISSION TO NAIC.—At the same time MedPAC submits the report to Congress under clause (i), MedPAC shall transmit such report to the NAIC.

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